Adopted December 12, 1997 by the Managed Health Care Improvement Task Force

ACADEMIC MEDICAL CENTERS
FINDINGS

I. INTRODUCTION

The purpose of this paper is to document the trends and changes in health care delivery and managed care plans and how they have affected Academic Medical Centers (AMCs) and health professions education. While this paper focuses on the issues of physician education, the Task Force recognizes that managed care has had profound affects on how all health professionals deliver services and are, or should be, trained. The Task Force encourages the monitoring of the impacts of the changing health care system on the staffing needs, initial training, and ongoing professional development of the full spectrum of health professionals.

A. Role of Academic Medical Centers in the Health Community

California has eight allopathic medical schools and one osteopathic medical school. Five of the eight allopathic schools are part of the University of California (UC) system (UC-Davis, UC-Irvine, UC-Los Angeles, UC-San Diego, UC-San Francisco). The other three allopathic schools (Loma Linda, Stanford, and University of Southern California) and the osteopathic school (Western University of Health Sciences) are private. In the 1995-1996 academic year, the eight allopathic medical schools enrolled 4,366 medical students, and the osteopathic school enrolled 681 students. The five UC schools accounted for approximately 50% of first-year enrollees. In 1995, there were 645 allopathic residency programs in California, which enrolled a total of 8,678 residents, and slightly over half of these residents were enrolled in programs affiliated with the UC system.[1] Although a great deal of training occurs in public hospitals, due to the complexity of obtaining financial data for the various teaching institutions, the Task Force narrowed it scope to focus primarily on the AMC-owned, university teaching hospitals. These centers include: UCLA Medical Center, USC Medical Center, University of California at Irvine Medical Center, University of California at Davis Medical Center, Loma Linda University Medical Center, UCSD/San Diego University Medical Center, UCSD/La Jolla Thorton Hospital, Medical Center at UCSF, and Stanford University Medical Center.

[1] Coffman, J, et al., "California Needs Better Medicine: Physician Supply and Medical Education in California," A Joint Publication of the California Primary Care Consortium and the UCSF Center for Health Professions, May 1997.

1. Education
One of the core missions of all AMCs is medical education and training. AMCs provide undergraduate and graduate medical training in a unique environment that brings together education with research and patient care. Although AMCs educate and train many types of health professionals, the focus of this report is on those activities that prepare individuals to practice medicine and/or conduct health-related research.

2. Research
The United States has been the world's biomedical research leader over the past half-century and is home to the world's leading experts in nearly all fields of biomedical research. The preeminence attracts scientists from around the globe to study and work at AMCs throughout the country. California's AMCs have been both world and national leaders in ground-breaking research. In addition to the improvements realized in medical care, this investment has also fueled the growth of the biotechnology, pharmaceutical, and medical equipment industries. These are exceptionally high-value-added industries, which, for that reason, make a great contribution to the growth of the California economy.

3. Clinical Care
AMCs apply leading edge technology in the treatment of disease and serve as sources of clinical innovation for the rest of the industry. They operate as "centers of excellence" providing tertiary care to a more acute patient population, as well as providing a great deal of routine care. These centers provide a disproportionate amount of care to vulnerable populations and serve as part of the societal safety net.[2]

B. Transition of Health Delivery System
AMCs are based in the most complex and specialized part of the delivery system. They make use of and develop the latest in medical technology, have traditionally valued the specialist over the primary care provider (PCP), and in the past their approach to the delivery of health care has been the least cost conscious. This orientation, if not addressed, sets them squarely on a collision course with the major transformation that is occurring in the broader health care system.

C. Concerns AMCs Have Related to Managed Care
1. ***AMCs fear loss of payment for public goods:*** Managed care, as the agent of major payors, is not willing to pay for certain public goods produced by AMCs. Concern exists that managed care organizations (MCOs) will not pay a premium to support education or clinical research.
2. ***Loss of payment for services:*** Managed care, the more competitive environment, and reduced payments by Medicare and Medicaid, have resulted in a decrease in the prices for services paid to AMCs.
3. ***AMCs fear loss of volumes:*** AMCs fear that lower referral rates from MCOs to AMCs for specialty care could lead to loss of revenues and patient volumes necessary to conduct training and research, although this has not been the experience in California so far.
4. ***Adverse selection:*** Patients most likely to stay with AMCs are those most dependent on their services; this group includes the indigent and those with highly unusual or costly tertiary care needs.
5. ***Loss of Disproportionate Share Hospital (DSH) funds:*** Medi-Cal recipients are being enrolled in managed care, and AMCs are often unable to compete for members who, for the first time, have a

[2] Mann, J, et al., "A Profile of Uncompensated Hospital Care, 1983-1995," *Health Affairs*, July/August, 1997.

choice of health plan and delivery system. Enrollees may prefer to establish a relationship with a non-AMC provider, or they may choose to receive care at a facility more easily accessible. The voluntary and involuntary movement of Medi-Cal recipients from AMCs that receive Medi-Cal DSH funds and other traditional safety-net providers to non-safety-net providers reduces the financial resources of AMCs and other traditional safety-net providers. AMCs are concerned that the private providers may enroll the healthiest populations, leaving the sickest and most costly for the safety-net providers. Also, although recently reversed under the new Balanced Budget Act, AMCs experienced a loss of Medicare Graduate Medical Education (GME) funds when health plans received Medicare capitation payments based on a formula that included allowances for teaching hospitals, and failed to pass them through to the AMCs.

II. FINDINGS

A. Health Profession Education

According to several leading authorities, too many specialists are being trained in California, as well as in other parts of the country.[3] Under new legislation, the Health Care Financing Administration (HCFA) is now offering incentives to AMCs to reduce their residency programs, and this appears to be desirable public policy. Although some progress has been made in California towards shifting the primary care-specialist mix, overall the change has not been substantial. Stanford maintains a 71% specialist to 29% primary care ratio with no plans to adjust in the future.[4] UC entered a voluntary agreement with the state to adjust the mix, but other California AMCs are not bound by this agreement. It would be beneficial if the leaders of California's AMCs would work together to develop an authoritative projection of physician personnel (and other health professionals) needs and a plan for adjusting educational programs to meet them.

Clinical education has traditionally taken place in the inpatient setting and clinics of affiliated hospitals. However, this no longer provides adequate preparation for practice as advances in medical knowledge and improved technologies have lowered hospitalization rates, reduced lengths of stay, and shifted care to ambulatory settings (outpatient departments and physicians' offices). Also, society's need to contain the cost of medical care and to produce more primary care physicians, with a focus on population-based medicine, requires greater student exposure to physician and public health practice in community and ambulatory sites, including managed care practice settings.

Although this section focuses on graduate medical education of physicians, many analogous observations would apply to the training of other health professional personnel. As the composition of non-physician health care personnel changes to reflect managed care's effort to cut costs while continuing to meet patients' medical needs, various professions will share some of the tasks that have historically been reserved for the physician. Training programs and demand for certain groups of health care providers, including advanced practice nurses and physician assistants have been increasing.[5] Health care employers in California have indicated that they will significantly increase the number of advanced practice nurses they employ over the next several years.[6] It will be important that educational programs, where possible, be integrated across professional communities to prepare PCPs,

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[3] Op-Cit., "California Needs Better Medicine: Physician Supply and Medical Education in California," May 1997 and "Critical Challenges: Revitalizing the Health Professions for the Twenty-First Century," Pew Health Professions Commission, December, 1995.

[4] Interview with Ann Dohn, Director, Office of Graduate Medical Education, Stanford School of Medicine, September 1997.

[5] UCSF Center for the Health Professions.

[6] California Strategic Planning Committee for Nursing, *Planning for California's Nursing Workforce*, 1996.

nurse practitioners, and physician assistants to work together collaboratively in primary care settings. This should occur through increased sharing of clinical training resources, more cross-teaching, more exploration of the various roles played by professionals, and the active modeling of effective team integration in the delivery of efficient, high-quality care.

B. Financing and Data

An appraisal of the financial impact of managed care is made difficult by the fact that the financial data of AMCs are incomplete and uncertain, and by the fact that change has been very rapid in the recent years, and that published data in recent years are not yet available. Mission-based accounting systems are not in place, identifying and tracking revenues and expenses related to education, research, and clinical care is not possible. Accounting systems are not centralized, so a complete assessment of the financial performance of the medical school, hospitals, and faculty practice plans proves difficult. Data do not exist that combines information from these various entities in a useful manner. Currently there are separate surveys of medical schools, faculty practice plans, and hospitals, and it is not possible to balance the accounts between these surveys.[7] No California AMC publishes a consolidated statement of total revenues and expenses. Even within the different entities the data are often hard to understand. For example, faculty practice plan revenues have historically been unaudited and underreported, and billing systems have been maintained by individual departments.

In the past, AMCs used clinical revenues generated from hospital and faculty practice plans to cross-subsidize their teaching and research missions. A reasonable and probable inference from the available data is that the actions of managed care, in parallel with similar actions by Medicare and Medicaid, are reducing contract rates and squeezing the net income margins of AMCs, challenging their ability to continue to finance teaching and clinical research. AMCs recognize the need to make major changes to adapt to this new environment, and are working hard to make them. In recent years, they have taken many millions of dollars out of their cost structures. So far there have not been significant reductions of medical education, residency training, or clinical research in California.

The education and appropriate training of medical providers is a public good. The financial support for medical education has never been clearly defined. To a substantial degree, the cost of medical education has been supported by clinical revenues through cost shifting. As pressure on reimbursement intensifies and clinical revenues are threatened, more discrete funding streams need to be identified. It is in the interest of the public to define the cost of medical education and to develop stable funding mechanisms for the continued excellence of medical education.

A major problem for managed care in California results from the fact that patients want access to costly therapies whose efficacy has not been substantiated by controlled clinical trials or other convincing evidence. New treatment modalities need to be evaluated rigorously, under carefully designed and controlled clinical trials, to establish whether they should be included in a standard of care. AMCs, in particular, have the capability to conduct such studies. When appropriate, managed care organizations and other payors should support such studies in order to identify which technologies do and do not contribute to patients' health.[8] (Refer to Improving the Delivery of Care and Accountability in the practice of Medicine paper regarding coverage of clinical trials.)

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[7] Reuter, J, "The Financing of Academic Health Centers," Georgetown Univeristy Medical Center's Institute for Health Care Research and Policy, April 1996.

[8] AAHP Press Release, June 30, 1997.